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Health Services

AEROMEDICAL EVACUATION OPERATIONS AND MANAGEMENT

COMPLIANCE WITH THIS PUBLICATION IS MANDATORY

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This instruction implements Air Force Policy Directive (AFPD) 41-3, *Worldwide Aeromedical Evacuation*, by providing guidance and procedures for the operation and management of the aeromedical evacuation (AE) system. Use in conjunction with AFPD 41-1, *Health Care Programs and Resources*, Air Force Joint Instruction (AFJI) 41-301, *Worldwide Aeromedical Evacuation System*, Air Force Instruction (AFI) 41-106, *Medical Readiness Planning and Training*, Department of Defense 4515.13-R, *Air Transportation Eligibility*, January 1980, with Change 1, and other pertinent instructions and handbooks providing guidance concerning aeromedical evacuation. Send comments and suggested improvements on AF Form 847, **Recommendation for Changes of Publication,** through channels, to HQ AMC/SGX, 502 Scott Drive, Room 226, Scott AFB IL 62225-5319. See **Attachment 1** for a glossary of references, abbreviations, acronyms, and terms.

Chapter 1

GENERAL INFORMATION

1.1. Directive This instruction provides directive guidance for the management of the worldwide aeromedical evacuation (AE) mission. Use this instruction with applicable Department of Defense (DoD) and US Air Force (USAF) regulations.

1.2. Aeromedical Airlift Authority. Authority for patient and attendant aeromedical airlift and applicable conditions and restrictions are contained in DoD Regulation 4515.13-R, *Air Transportation Eligibility*, January 1980, with Change 1, and AFI 41-115, *Authorized Health Care, Health Care Benefits, in the Military Health Services System*.

1.3. Operational and Administrative Responsibilities. AFJI 41-301 establishes operational and administrative responsibilities and procedures for worldwide AE. It applies to all armed forces medical treatment facilities (MTF) and AE units.

1.4. Waiver Authority. Headquarters Air Mobility Command, Command Surgeon (HQ AMC/SG), retains authority to waive provisions of this instruction relating to C-9 and C-141 AE operations. Headquarters Air Combat Command, Command Surgeon (HQ ACC/SG), retains authority to waive provisions of this instruction relating to C-130 AE operations. Send requests for waivers through command channels to either HQ AMC/SG or HQ ACC/SG. Subordinate units will not publish supporting directives without prior written approval from the office of primary responsibility (OPR).

1.5. Distribution. Units will order a sufficient quantity of this regulation to provide copies for AE unit commanders and key executive staff members, flight crew information file, and unit mission kits. Do not distribute to individual unit members.

Chapter 2

OVERVIEW OF AEROMEDICAL EVACUATION

2.1. AE Mission. The mission of the worldwide AE system is to transport by air casualties:

- Requiring health care management.
- From forward airfields in the combat zone to points of definitive medical care.
- From one theater of operation to another.

2.1.1. Prepare for this mission during peacetime by:

- Training.
- Organizing and equipping assigned personnel.
- Instructing DoD medical treatment facilities on the use of the AE system.
- Exercising and evaluating contingency AE capabilities.
- Identifying medical and support equipment necessary to meet mission requirements.

2.1.2. A by-product of this mission: it provides to authorized personnel safe and quick transportation between medical treatment facilities in peacetime.

2.2. AE Program. HQ AMC is the executive agent for worldwide aeromedical evacuation. HQ AMC/SG is the oversees the worldwide AE system, establishing, in coordination with the Air Reserve Component (ARC) Surgeons, Air Force Component Command Surgeons, and other Major Command (MAJCOM), the standards for system-wide organization, equipage and training of the AE force. The multi-agency Aeromedical Evacuation Readiness Committee (AERC) structure facilitates this process. Total Force, multi-command coordination ensures standards for system-wide AE crew and AE mission support training requirements, for clinical and in-flight care, and for AE crew performance.

2.2.1. AE forces serve in active duty commands (Air Mobility Command [AMC]).

2.2.2. Air Combat Command [ACC], United States Air Forces in Europe [USAFE], Pacific Air Forces[PACAF], and the Air Reserve Component [Air Force Reserve (AFRES) and Air National Guard (ANG)]). AMC is the gaining MAJCOM for intertheater AE mission and mission support forces, including elements supporting theater/intertheater interface and the strategic route support structure. ACC provides AE forces to Unified Commanders for intratheater AE mission execution.

2.2.3. Airlift Resources. The primary Air Force aircraft supporting intratheater AE is the C-130 Hercules. Overseas theater commanders have operational control of theater-assigned or attached aircraft through the Airlift Operations Center (AOC), who allocates those airframes as required to meet operational mission requirements. Primary intertheater aircraft include the C-141 Starlifter, C-5 Galaxy, AMC tanker aircraft and the Civil Reserve Air Fleet (CRAF), when tasked. The C-9A Nightingale can be used to support both intratheater and intertheater AE missions.

2.2.4. Aircraft Availability. Support AE missions using:

- Dedicated aircraft.
- Opportune aircraft.

- Scheduled AE channel missions.

2.2.4.1. In all cases, base the decision to use a specific aircraft on:

- Clinical requirements.
- Specific medical equipment needs.
- Timeliness of patient movement.
- Financial constraints. ***Note: Manage and report missions supported by opportune aircraft in the same manner as other AE missions.***

2.3. AE Organization. An interrelated network consisting of intratheater and intertheater subsystems connects AE operations. The designated theater Aeromedical Evacuation Control Center (AECC) directs and manages missions originating and terminating within one theater (intratheater). The Tanker Airlift Control Center (TACC) located at Scott AFB IL manages intertheater missions. Intertheater AE missions will usually originate at a designated intertheater interface point and terminate at a pre-defined reception airfield in the Continental United States (CONUS). The respective Joint Medical Regulating Office (JMRO) and Armed Services Medical Regulating Office (ASMRO) will regulate appropriate follow-on transportation for patients requiring transport beyond the CONUS reception airfield. CONUS AECC will execute the AE mission within CONUS. The following elements manage AE operations, with staffing according to unit type codes (UTC).

2.3.1. Medical Regulating Offices (ASMRO/JMRO). Medical regulating offices regulate patients within assigned theaters. They ensure patient care requirements are matched to existing medical capability. ASMRO is a tri-service, United States Transportation Command (USTRANSCOM) agency responsible for patient regulating to and within CONUS. Theater JMROs are Unified Command agencies designated to regulate patients within their theater. JMROs also coordinate intertheater patient regulating requirements and advise the theater AECC of patient movement requirements. Through a USTRANSCOM initiative, intertheater regulating and command and control functions performed by the ASMRO and CONUS AECC are integrated into a Global Patient Movement Requirements Center (GPMRC) to provide a single office for regulating and moving patients. The theater commander can establish a Theater Patient Movement Requirements Center (TPMRC) with advice from the theater surgeon and the Director of AE Forces (DIRAEFOR).

2.3.2. Aeromedical Evacuation Coordination Center (AECC). The AECC is the theater coordinator for all aeromedical evacuation activities. The AECC goal is to provide safe and quick aeromedical movement that is responsive to patient needs. Specifically, the AECC manages intratheater aeromedical evacuation, matches requests for aeromedical evacuation with available resources, and coordinates intertheater AE support provided by HQ AMC TACC, Scott AFB IL. Staff AECCs 24 hours a day. During contingency operations, augment theater AECCs as required.

2.3.3. Aeromedical Evacuation Operations Team (AEOT). Assign AEOTs under the operational control of the theater AECC. Their primary function is to provide AE mission launch and recovery support during contingency operations. Specific responsibilities include managing AE crews, AE mission support activities, and AE equipment, supplies and kits.

2.3.4. Aeromedical Evacuation Liaison Team (AELT). AELTs provide liaison services and direct high frequency radio communication among the service agencies, the medical facilities, and the intratheater AE system during contingency operations.

2.3.5. Aeromedical Staging Facilities (ASF). ASFs and Mobile ASFs (MASFs) support patients (both medically and administratively) entering, transiting, or leaving the AE system. ASFs are established at fixed locations in peacetime and strategic interface airfields in contingencies. MASFs can deploy rapidly to locations supporting tri-service forward medical operations. Refer to AFI 41-305, *Administering Aeromedical Staging Facilities*, for further information related to ASF/MASF operations.

2.3.6. AE Mission Support Operations. Designated MTFs at intertheater AE interface locations are responsible for AE mission support activities. General responsibilities include patient staging, patient movement, mission administrative support, and AE equipment management. These MTFs must provide this support for all AE missions originating in, transiting, or departing their location. The tasked Medical Group Commander determines specific duties and staffing requirements.

2.3.7. AE Crews. The standard AE crew is two flight nurses (FN) and three aeromedical evacuation technicians (AET). Adjust the crew size to meet specific AE mission requirements, according to applicable MCR 55-series publications. AE crews will use abbreviated checklists, as outlined in **Attachment 1**attachment 1 and **Attachment 2**attachment 2 of AFI 11-215, *Flight Manual Program.*

Chapter 3

AE OPERATIONS MANAGEMENT

3.1. AE Operations Management. A physician will decide to enter a patient into the AE system based on clinical need, considering local capability limitations and all medical treatment alternatives. Generally, no one may request patient movement until after the physician determines that care is not available locally or that the patient cannot be returned to duty within the prescribed theater evacuation policy. AE personnel provide medical care and treatment to patients according to Air Force Joint Handbook (AFJH) 41-306, *Physician's Roles and Responsibilities in Aeromedical Evacuation,* and Air Force Handbook (AFH) 41-309, *Aeromedical Evacuation Equipment Standards.*

3.2. HQ AMC/SG:

- Develops supporting plans for strategic AE, CONUS reception AE, and provides guidance to theater planners for intertheater AE operations.
- Augments AMC Numbered Air Force to perform Aircrew Standardization/Evaluation visits to active duty and ARC AE units having intertheater AE missions.
- Monitors the readiness status of AMC-gained ARC AE units.
- Identifies requirements for research and development of medical equipment used in the AE system.
- Establishes requirements for the quality improvement/risk management (QI/RM) program for the worldwide AE system.
- Produces Statistical Summary History Reports of AE missions.
- Provides policy and procedural guidance for the procurement of medical materiel needed to accomplish the AE mission.
- Retains all AE mission manifests, nursing notes, and travel authorizations for two years (current and prior fiscal year).
- Provides consultation for Deployable Medical Systems (DEPMEDS) and Wartime Medical Planning System (WARMED PS) pertaining to global AE.

3.3. HQ AMC Tanker Airlift Control Center (TACC). The TACC is responsible for executing all intertheater AE missions. HQ AMC TACC will:

- Identify intertheater airlift resources available to augment theater AE requirements when requested by theater AECC.
- Determine feasibility and direct use of opportune aircraft to meet specific patient movement requirements, when appropriate.
- Manage intertheater AE mission execution, coordinating with originating and terminating theater AECCs.
- Contact all concerned agencies when a scheduled AE mission in progress is diverted or delayed for any reason.

- Submit RCS: HAF-SG(D)9455, *Daily AE Mission Activity Report*, reflecting worldwide AE activity data to Headquarters Air Mobility Command, Command Surgeon Program Analysis Office (HQ AMC/SGXO), 502 Scott Drive, Room 226, Scott AFB IL 62225-5319, by 0700 local each day. See **Attachment 2**attachment 2 for instructions.

3.4. Airlift Operations Center (AOC). The respective theater AOC manages airlift operations within an overseas theater. AE, as part of the airlift system, must maintain a close working relationship with the AOC. During contingency operations, the AECC is aligned under the AOC and AECC submits requests for AE to the AOC. The AOC will schedule aircraft departure times only on the basis of fully mission capable aircraft.

3.5. Theater Surgeon and Air Force Component Surgeon. Will:

- Provide professional oversight to the AE system.
- Provide intertheater AE mission operations support when requested.
- Coordinate all policies, procedures, equipment requirements and use, and training standards with HQ AMC/SG to ensure standardization of the worldwide AE system.
- Establish theater procedures.
- Forward requests for intertheater Invited Medical Personnel (IMP) status to HQ AMC TACC/ DOOMM at least five days prior to the scheduled AE mission.
- ARC AE commanders may authorize IMP status on Aeromedical Readiness Missions (ARM).

3.6. Aeromedical Evacuation Squadron (AES). The AES is the principle organization responsible for executing all aspects of the AE missions within their assigned theater. Major functions include accepting patient movement taskings, scheduling AE missions to meet patient movement requirements, facilitating patient preparation, and providing in-flight nursing care for patients in the AE system.

3.6.1. AES Commander will:

- Ensure the unit is capable of meeting assigned Designed Operational Capability (DOC) tasks-ings.
- Appoint a resource manager who is responsible for managing all unit resources.
- Appoint a medical readiness officer who will manage the unit readiness training program according to instructions in **3.6.14.**paragraph 3.6.14.
- If unit has an operational patient AE mission tasking, develop an active quality improvement / risk management (QI/RM) program, as outlined in **Chapter 5**Chapter 5 of this instruction.
- Appoint an officer or Noncommissioned Officer (NCO) as the Status of Resources and Training System (SORTS) monitor according to AFI 10-201, *Status of Resources and Training System*.
- Appoint an Non-Commissioned Officer (NCO), TSgt or above, as unit property custodian.
- Coordinate a training program with the commander and medical logistics officer of the host MTF if medical logistics personnel are assigned to the AES.
- Ensure the program includes ongoing refresher training and is conducted at the MTF.

- Ensure training emphasizes stock records and medical equipment management office functions.
- Ensure completion of forms per AFJMAN 41-313, *Aeromedical Evacuation Documentation.*
- Determine the minimum basic publications to be maintained by aeromedical evacuation crew members (AECM), AECM flight examiners (FE), and AECM flight instructors (FI).

3.6.2. Chief, AE Operations will:

- Assign AE operations officers to plan and execute AE missions.
- Direct unit administration and operational support technicians in their duties.

3.6.3. Chief Nurse will:

- Provide aircrew training required in AFI 41-304, *Aeromedical Evacuation Training and Education.*
- Conduct staff development programs to promote nursing practice proficiency according to AFJH 41-307, *Aeromedical Evacuation Nursing Considerations and Standards of Care*.
- Establish nursing standards of care and practice for in-flight patients according to AFJH 41-307.
- Determine medical crew complement based on level of nursing care required and capability of accompanying medical attendants for all intratheater AE missions and intertheater AE missions originating from their theater.

3.6.4. Aeromedical Evacuation Operations Officer (AEOO) will:

- Complete appropriate forms per AFJMAN 41-313.
- Perform duties as outlined in AFH 41-311, *Evacuation Operations Officer Training Standards.*

3.6.5. Standardization and Evaluation Officer or NCO will perform duties as outlined in AFI 11-401, *Flight Management,* and AFI 11-406, *Aircrew Standardization/Evaluation Program.*

3.6.6. Flight Nurse (FN) will:

- Provide professional nursing care during all aspects of AE missions assigned according to AFJH 41-307.
- Review and coordinate in-flight patient care requirements as required with origination and destination MTF personnel.
- Complete appropriate forms per AFJMAN 41-313.

3.6.7. Aeromedical Evacuation Technician (AET) will:

- Provide in-flight patient care under supervision of a qualified FN according to AFJH 41-307.
- Complete appropriate forms per AFJMAN 41-313.

3.6.8. Air Force Operations Resource Management System (AFORMS) Manager (when assigned) will perform duties as outlined in AFM 171-190, *Air Force Operations Resource Management System (AFORMS).*

3.6.9. AECC will:

- Obtain and review patient medical information related to AE and determine specific patient AE requirements.
- Match requests for aeromedical evacuation with available resources.
- For intratheater missions, determine feasibility and direct use of opportune aircraft for patient transportation, when appropriate.
- Coordinate with HQ AMC/TACC for all intertheater AE mission requirements, intratheater AE missions requiring intertheater aircraft resources, and strategic airlift resources.
- When indicated, coordinate with designated flight surgeon to facilitate safe patient transportation, including use of flight surgeon support for in-flight duties when required. ***Note: Flight surgeons or other physicians may be tasked to support AE crews on specific AE missions, as determined by the Air Component Surgeon or his designee.***
- Produce and control mission manifests.
- Use AF Form 3830, **Patient Manifest,** to record individual patient information related to each mission.
- Use AF Form 3829, **Summary of Patients Evacuated by Air**, to record mission information pertaining to crews, aircraft, itinerary, and numbers of patients.
- Develop and retain mission folders.
- Use AF Form 3835, **Aeromedical Mission Management-Part I**, to log mission events and flight follow missions.
- Use AF Form 3836, **Aeromedical Mission Management-Part II**, to document that specific required tasks are completed prior to departure of mission.
- If a terminating AECC, correct and annotate manifests of completed missions and forward to HQ AMC Command Surgeon Health Care Resources (HQ AMC/SGAR), 502 Scott Drive Room 226, Scott AFB IL 62225-5319, within 5 days of mission termination.
- Send travel authorizations collected on any revenue-reimbursable patient to HQ AMC/SGAR, within five days of mission completion.
- Ensure the authorization includes an appropriate billing address.
- Flight follow all intratheater AE missions.
- Contact affected agencies when an AE mission in progress is delayed for any reason.
- Send RCS: HAF-SG(D)9455, *Daily AE Mission Activity Report*, to HQ AMC/TACC/DOOMM daily. See paragraph 3.3.5 and **Attachment 2**attachment 2 for further details.

3.6.9.1. During contingencies, the AECC will:

- Contact the destination theater AECC and HQ AMC/TACC/DOOMM with information concerning the departure of any AE mission that is transporting unregulated patients. Include:
- Tail number of the aircraft.
- Departure time.
- Number of casualties aboard.
- Destination.

- Estimated time of arrival.
    - Advise HQ AMC/TACC/DOOMM of any individuals requiring AE who may be of special interest to the respective theater surgeon or MAJCOM/SG. Include:
- Clinical diagnosis.
- Pertinent patient data and history.
- AE mission routing.
- Additional information which may be of interest. ***Note: For further guidance on required reports refer to AFI 10-201 and AFH 41-312, Aeromedical Evacuation Contingency Operations Training (AECOT) Standards.***
    - Keep a log of noncertified medical equipment used in their area of responsibility. Include:
- Type of aircraft equipment was used on.
- Comment on continuous or intermittent use.
- Comment on use in all phases of flights or crew flights only.
- Product name.
- Model number.
- Any problems reported by flight or medical crew. ***Note: A copy of this log should be submitted semiannually to HQ AMC/SG.***

3.6.10. Aeromedical Evacuation Crew Members (AECM) will:

- Follow the crew duties outlined in the mission design aircraft abbreviated checklist and the Cardiac Arrest In-Flight checklist found in AFJMAN 41-313. ***Note: The AES Training Office is responsible for incorporating these into the abbreviated checklist.***
- Use Emergency and Life Support Equipment required aboard AE missions, as specified in MCR 55-22, *Aircrew Life Support Program,* and aircraft Technical Orders (TO.).
- Operate only the flight certified medical equipment listed in AFJI 41-301 on any AE aircraft. ***Note: Theater validating flight surgeons may recommend the use of other than flight-certified medical equipment after considering previous use of the equipment, patient diagnosis, movement precedence, clinical status, length of flight, compatibility with aircraft, crew-to-patient ratio, and availability of alternate medical care and transportation. The validating flight surgeon must advise the attending physician and the aeromedical evacuation crew of known operational limitations of the equipment. Aircraft commanders have the final authority for use of non-certified equipment on board the aircraft.***
- Document problems associated with the use of non-certified equipment in section II, Remarks, of AF Form 3829.
- Follow operating instructions provided in AFH 41-309 when operating centrally procured equipment.
- Conduct preflight inspection of aircraft interior and of medical equipment, ensuring each item is complete and serviceable. (For any deficiencies or shortages, AECM will ensure correction.)

- Use Air Force Technical Order (AFTO) Form 781A, **Maintenance Discrepancy and Work Document,** (usually maintained by the flight mechanic or flight engineer) to report unserviceable aircraft emergency equipment items.
- Use AFTO 350, **Repairable Item Processing Tag,** for unserviceable medical equipment.
- Complete supply and equipment inventories upon mission termination using locally generated forms.
- Ensure patients, passengers, and crew follow all applicable customs and agricultural clearance procedures as described in AFI 48-104, *Medical and Agricultural Foreign and Domestic Quarantine Regulations for Vessels, Aircraft, and Other Transport of the Armed Forces*, and USAF Foreign Clearance Guide, as well as any local requirements of each country transited by AE aircraft.
- Ensure complete anti-hijacking procedures are accomplished according to AFJI 41-301.
- Load, maintain, and unload patient baggage during AE missions.
- Enforce and observe safety measures while performing the patient airlift mission.
- Frequently review emergency procedures outlined in aircraft TOs, required directives, and abbreviated checklists to ensure fully coordinated action of all AECMs. ***Note: Throughout the mission AECMs must remain alert for unusual occurrences and immediately report any safety hazard to the mission crew director (MCD) or aircraft commander.***
- Exercise extreme caution during loading and unloading procedures. ***Note: A high accident potential exists because of extreme noise, vehicle activity around the aircraft, and inclement weather.***
- Brief all patients and passengers on safety in and around the aircraft prior to loading or unloading. ***Note: Further information may be found in AFH 41-308, Aeromedical Evacuation Crew Member Training Standards.***

3.6.11. Property Custodian will:

- Maintain and monitor a using activity cost center with the host MTF.
- Be the responsible property officer for the unit as designated by the organization commander.
- Maintain equipment inventory records and ensure current authorized and in-use assets are recorded on the Custody Receipt/Locator List.
- Submit supply and equipment requests to the MTF or Base Supply.
- Accomplish necessary coordination with appropriate base activities such as Medical Logistics, Medical Maintenance, Accounting and Finance, Base Contracting, and Base Supply, as appropriate.
- Submit all materiel complaints through the base MTF, or base supply for non-colocated ARC units, according to AFMAN 23-110, *USAF Supply Manual* (formerly AFM 67-1, volume V, *Air Force Medical Material Management System-General*).
- When unusual materiel problems occur, request assistance from applicable MAJCOM. ***Note: Request assistance from the MTF prior to forwarding request for assistance to the MAJCOM.***

3.6.12. Materiel Management will:

- Use Table of Allowance (TA) 887, *Strategic and Tactical Aeromedical Evacuation (AE) In--flight kits (WRM),* and TA 903, *Aeromedical Staging flight (WRM),* to establish the minimum supply and equipment requirements for contingency and noncontingency AE operations. ***Note: For non-contingency operations, AE units may add supplies and flight-certified medical equipment to meet unique mission needs.***
- Maintain sufficient inventory of supplies as required to support tasked AE missions.
- A maximum 30-day stock of consumable medical and nonmedical supply is authorized.
- Keep quantities of non recurring or infrequently used supplies to the minimum.
- Determine stock levels by using the activity stock status report.
- Request all unit medical supplies through the base MTF medical logistics office or base supply for noncolocated ARC units.
- Order in sufficient time to maintain adequate stock levels. ***Note: Initial requests for local purchase (nonstock listed) supplies may take 30 to 45 days to process.*** In certain overseas areas, this time frame could be longer. When procuring from local purchase sources, use blanket purchase agreements or federal supply schedules to the maximum extent possible.
- Store materiel according to guidelines in:
- AFMAN 23-110 (formerly AFM 67-1, volume V).
- AFI 124-204, *Preparing Hazardous Materials for Military Air Shipment.*
- Air Force Occupational Safety and Health (AFOSH) 127-8 , *Medical Facilities.*
- Maintain all medical materiel items in a secure, clean, and orderly environment and store in a logical manner.
- Provide special precautions to those items requiring protection from light, temperature, humidity, rodents, insects, and fungal damage.
- Conduct a thorough quality control inspection of material on hand to ensure all supplies are serviceable and have sufficient shelf life.
- Constantly monitor dated items to preclude expiration.
- Rotate stocks as needed. ***Note: If practical, exchange older stocks with the supporting MTF.*** Once an item is issued from the MTF, the AE unit is responsible for monitoring the expiration date.
- Use AFR 67-43, *Quality Control Depot Serviceable Standards-Appendix M--Medical Supplies*; Defense Personnel Support Center (DPSC) Handbook 4140.1, *Consolidated Defective Medical Materiel List*; and Air Force Medical Logistics Letters to perform required checks.
- Appropriately maintain all controlled substances and account for them at all times.
- Immediately report discrepancies in drug quantities to the unit commander and Security Police, and coordinate with the MTF. ***Note: Refer to AFMAN 23-110 (formerly AFM 67-1, volume V), for procedures for managing controlled drugs.*** The Office of Special Investigation forwards one copy of all approved inventory adjustment vouchers and reports of survey pertaining to controlled substances to the MAJCOM Surgeon.
- Store and maintain dangerous materials (flammable, corrosives, oxidizers, compressed gases, etc.) according to Occupational Safety and Health Administration (OSHA), Air Force, and

other applicable governing regulations. ***Note: AFI 124-204 provides guidance to identify these items.***

- Obtain instructions for disposal and turn-in of hazardous materials from the local MTF.
- Establish procedures to prevent occurrences of theft, vandalism, or unintentional damage. ***Note: Refer to AFI 31-209, The Installation and Resource Protection Program for guidance.***
- Keep medical equipment stored in protective cases except when in use, in maintenance, or circumstances dictate otherwise.
- Permanently mark or etch equipment items, subject to pilferage, to identify the squadron or group owning the equipment. ***Note: This marking should be coordinated with the MTF and be accomplished in a way that does not deface the equipment.***

3.6.13. Equipment Management Office will:

- Obtain necessary approvals when purchasing equipment items.
- Send requests for AE expense equipment to the unit or organization commander for approval.
- Send requests for investment equipment to appropriate MAJCOM for approval and subsequent funding action.
- Prepare and send AF Form 601, **Equipment Action Request,** to the MTF, or base supply for non-colocated ARC units, after approval of the organization commander. ***Note: Funding for investment equipment is provided separately.*** All AE equipment must be initially approved by HQ AMC/SGX and tested by the USAF School of Aerospace Medicine prior to use and operation on AE aircraft.
- Initiate the acquisition and development process according to AFPD 10-6, *Mission Needs and Operational Requirements*, and AFI 10-601, *Mission Needs and Operational Requirements Guidance and Procedures*, when ordering AE-unique equipment.
- Assume custodial responsibility for equipment issued to the account and ensure all items are properly maintained and safeguarded.
- Perform an inventory of all equipment assets at least annually, and provide a signed copy of Custody Receipt/Locator List to the MTF.
- Turn in replaced or excess equipment to the host medical logistics account when no longer required. ***Note: Equipment items being replaced may be retained for 30 days to allow unit personnel to become familiar with the replacement item.***
- Account for computer equipment on Base Data Automation Records.
- Obtain necessary equipment maintenance support.
- Send medical equipment requiring maintenance to the medical equipment repair activity of the MTF.
- Obtain equipment repairs beyond the capability of the MTF from the regional Medical Equipment Repair Center (MERC).

3.6.14. Medical Readiness Officer will:

- Coordinate and monitor unit readiness training as specified in AFI 41-106, *Medical Readiness Planning and Training*, and AFI 32-4001, *Planning and Operations*.

- Review, coordinate, and write unit contingency plans and other plans applicable to the unit.
- Follow guidance contained in AFI 41-304 for additional requirements for AE training programs.

3.7. Medical Crew Director (MCD). MCDs will:

- Notify the reporting AECC when designating a patient as "special."
- Determine the most acceptable alternatives for patient holding and care during mission delays.
- Coordinate with the theater AECC to determine sources of local medical care appropriate to patient needs when an unscheduled remain overnight is required.
- Ensure AF Form 3841, **Certificate of Release**, is completed when a non-active duty patient requests release from the AE system during a mission. ***Note: The individual's signature on the AF Form 3841 indicates release of the AE system from responsibility and liability for patients requesting release from the AE system.***
- Release active duty patients only upon a competent medical authority's recommendation and with the concurrence of the active duty member's commander.
- Collect all copies of temporary duty orders and IMP authorizations from personnel flying in an IMP status and place in the appropriate AE mission folder.

3.8. Guards of Prisoner Patients. Will:

- Accompany assigned prisoner-patients to their destination facility.
- Turn in weapons and ammunition to the aircraft commander, as required by appropriate MCR 55-series regulations.
- Decide when handcuffs may be removed from the patient while the aircraft is in flight.
- Not handcuff prisoners to any portion of the aircraft.

3.9. Medical Treatment Facility (MTF). MTFs will:

- Ensure a DD Form 2239, **Consent for Medical Care and Transportation in the Aeromedical Evacuation System,** or a power of attorney (POA) accompanies any unaccompanied minor (under the age of 18) or any unaccompanied non-active duty patient who is not capable of directing his or her own care.
- Annotate the parent's or guardian's address and telephone number on the form, file the original in the patient's medical record, and attach a copy to the patient's DD Form 602, **Patient's Evacuation Tag.**
- Provide the POA to the military aeromedical evacuation system or medical crew.
- Ensure minors under the age of 14 have an attendant. ***Note: If a parent or guardian doesn't accompany the minor, the originating medical facility must supply a responsible adult, and the DD Form 2239 or POA must be made out to the adult to cover the flight.***
- Process patient baggage separately from passenger baggage.
- Perform an anti-hijacking inspection of all persons and hand-carried articles transported in the AE system.

- Ensure patients or attendants check no more than two pieces of baggage, not exceeding 66 pounds total, plus one hand-carried item.
    - Ensure the owner disposes of any excess baggage. ***Note: The MTF commander may authorize up to 100 pounds total for US active duty Armed Forces patients, based on individual circumstances.*** If done, the MTF will include this authorization in the patient's orders. Refer to AFJI 41-301 for further guidance.
- Assure guards have been provided for prisoners on AE missions.
- Complete appropriate forms according to AFJMAN 41-313.

3.10. Invited Medical Personnel (IMP). HQ AMC/TACC/DOOMM manages the IMP program for intertheater missions; each theater AECC manages the IMP program for intratheater missions. Responsible parties will retain appropriate management data for the IMP program, including personnel granted this status, dates of mission, recommendations made by the observer, and follow-up actions (where appropriate).

Chapter 4

CONTINGENCY OPERATIONS

4.1. Scope. The wartime AE system must be able to support the entire spectrum of conflict from operations other than war to global war. Accomplish this by tailoring AE forces to meet operational requirements.

4.2. Contingency AE Organization. The AE organization established within the theater will provide administrative command. Establish AE group or squadron headquarters, depending on the number of forces employed within the theater and the operating locations involved.

4.2.1. The group headquarters will manage theater AE forces and all theater AE operations.

4.2.2. The squadron headquarters will manage regional AE forces, where established.

4.2.3. A senior AE commander, who is an integral part of the AOC staff, will manage theater AE resources.

4.2.4. Operational AE elements, when employed, will support patient entry into the theater or intertheater AE system and affect patient AE between echelons of care within the theater and to intermediate theaters and/or CONUS.

4.2.5. Regional commanders, when established, will provide command and oversight for AE forces operating within their assigned region.

4.2.6. The supporting MAJCOM will deploy the UTCs which comprise the element's Advanced Echelon (ADVON), AE Support Cell, Squadron Headquarters, and Group Headquarters, using a building block concept to provide the required command and staff overhead to manage the deployed AE system. The number of operational AE elements employed will depend on the supported theater's AE Concept of Operations. Considerations include the Theater Evacuation Policy, the number of airfields selected to support patient movement, evacuee projections, and liaison requirements with the user service medical support system.

Chapter 5

QUALITY IMPROVEMENT/RISK MANAGEMENT(QI/RM) PROGRAM

5.1. Scope. This chapter defines the requirements and responsibilities for QI/RM programs within the AE system. Each AE unit participating in operational patient mission taskings must develop an active QI/RM program. Units not participating in operational missions are strongly encouraged to develop and implement a QI/RM program. Forward trend data for review to the parent MAJCOM.

5.2. References. Joint Commission on Accreditation of Healthcare Organizations (JCAHO) Standards; AFJH 41-307 and AFI 44-119, *Quality Assurance and Risk Management in the Air Force Medical Service.*

5.3. Intent of Program. This instruction describes an integrated QI/RM program at the AE squadron level. It provides a structure for engaging DoD, HQ USAF, and MAJCOM support for resolving system-related quality-of-care issues. All personnel assigned to an AE unit supporting operational patient missions must be actively involved in these programs, defining standards, documenting care, improving care, and ensuring standards are met or exceeded. MAJCOMs and higher headquarters will use trend data to adjust policies as needed to improve processes and patient care.

5.4. Objectives of QI/RM in AE. These include but are not limited to:

- Ensuring patient care standards and continuity of care are maintained.
- Ensuring ongoing and systematic process for accessing the quality of patient care.
- Reducing risk of adverse clinical outcomes or incidents.
- Improving patient satisfaction with the AE system.
- Educating AE personnel on all aspects of the QI/RM program.
- Ensuring personnel are updated on QI/RM information.
- Ensuring QI/RM implements mechanisms to assess and monitor system-wide problems.

5.5. Responsibilities:

5.5.1. MAJCOM Surgeon.

- Responsible for QI/RM program for MAJCOM.
- Appoints a QI manager.
- Ensures standards for medical consideration for patient airlift are developed, implemented and measured.

5.5.2. MAJCOM QI Manager. Defines a process for oversight management of elevated quality issues.

5.5.3. AE Unit Commander.

- Ensures that an integrated QI/RM program is established and that a written QI/RM plan is developed to guide the program.

- Ensures there is a process in place for ongoing identification of opportunities for continuous improvement.
- Approves and forwards an annual AE QI program appraisal to MAJCOM/SG.
- Reports information concerning urgent or adverse QI/RM issues or patient outcomes to MAJCOM/SG as appropriate.

5.5.4. Unit Executive Committee.

- Ensures policies and procedures for governing the management for the QI/RM program are established.
- Provides oversight of the QI/RM function.

5.5.5. Unit QI Function.

- Convenes as necessary to ensure quality and appropriateness of care and service are monitored and evaluated.
- Systematically and continually reviews quality indicators and data (i.e., patient questionnaires, technical outcome indicator results, incident reports, mobility data, etc.) to ensure that all issues which could result in an opportunity for improvement have been adequately addressed.
- Institutes improvement strategies for issues within its control and recommends corrective measures beyond its authority to the executive committee.
- Reviews AE unit QI/RM program annually for appropriateness of scope, structure, and priorities, and recommends changes accordingly.

5.5.6. Unit QI Function Membership. All areas within the AE unit should have representatives at the QI function.

5.5.7. Nursing Services. Establishes a monitoring and evaluation (M&E) program using the established AE standards of care (SOC) in AFJH 41-307. These SOCs focus on high-volume, high-risk, and problem-prone patients who are routinely transported on AE missions.

5.6. Annual QI/RM Program Analysis:

5.6.1. Each January, the unit will prepare an appraisal (RCS: DD-HA(A)1898, *Annual Summary of Licensure Data*) of its QI/RM program for submission to HQ AMC/SG (with an info copy to its respective MAJCOM). Suspense for submission of this report is 15 Feb. The unit QI/RM plan is the basis for the report. In completing the report, consider the following issues concerning the unit's QI/RM plan:

- Identify the important aspects of care, the development of indicators thresholds for evaluation related to patient care and services, and the process for collecting, analyzing, and reporting data.
- Determine if patterns of performance or trends were identified, if appropriate actions were taken, and if the actions taken were effective.
- Identify any opportunities for improvement in the AE system and the process used.
- Identify any special training opportunities for quality management in the AE unit.

- Identify the top five QI concerns for the unit, giving special emphasis to issues beyond the unit's control. ***Note: Information about urgent or adverse QI/RM issues or patient outcomes should be reported immediately to the MAJCOM/SG, as appropriate.***
- Provide recommendations for improving the QI/RM program structure for either local, MAJCOM, or AF-wide consideration.

5.6.2. HQ AMC/SG will use AE unit reports as the basis for preparing an AE summary for submission to HQ USAF/SGPQ by 15 Mar of each year. Summary format will be at the MAJCOM's discretion. Use AFI 44-119 to identify items to include in the summary.

ALEXANDER M. SLOAN, Lt General, USAF, MC
Surgeon General

Attachment 1

GLOSSARY OF REFERENCES, ABBREVIATIONS, ACRONYMS, AND TERMS

References

AFPD 10-6, *Mission Needs and Operations Requirements*

AFPD 41-1, *Health Care Programs and Resources*

AFPD 41-3, *Worldwide Aeromedical Evacuation*

DoD Regulation 4515.13-R, *Air Transportation Eligibility*, January 1980, with Change *1*

AFI 10-201, *Status of Resources and Training System, RCS: HAF--XOO (AR) 7112 (DD)*

AFI 10-601, *Mission Needs and Operational Requirements Guidance and Procedures*

AFI 11-215, *Flight Manual Program*

AFI 11-401, *Flight Management*

AFI 11-406, *Aircrew Standardization/Evaluation Program*

AFI 31-209, *The Installation and Resources Protection Program*

AFI 31-4001, *Planning and Operation*

AFI 41-106, *Medical Readiness Planning and Training*

AFI 41-115, *Authorized Health Care, Health Care Benefits in the Military Health Services System*

AFI 41-304, *Aeromedical Evacuation Education and Training*

AFI 41-305, *Administering Aeromedical Evacuation Staging Facilities*

AFI 44-119, *Quality Assurance and Risk Management in the Air Force Medical Service*

AFI 48-104, *Medical and Agricultural Foreign and Domestic Quarantine Regulations for Vessels, Aircraft and other Transport of the Armed Forces*

AFI 124-204, *Preparing Hazardous Materials for Military Air Shipment*

AFOSH 127-8, *Medical Facilities*

AFR 61-1, *Flight Management*

AFR 67-43, *Quality Control Depot Serviceable Standards--Appendix M--Medical Supplies*

AFR 168-13, *Quality Improvement and Risk Management in the Air Force Medical Service*

AFH 41-308, *Aeromedical Evacuation Crew Member Training Standards*

AFH 41-309, *Aeromedical Evacuation Equipment Standards*

AFH 41-311, *Aeromedical Evacuation Operations Officer Training Standards*

AFH 41-312, *Aeromedical Evacuation Contingency operations Training (AECOT) Standards*

AFJH 41-306, *Handbook for Physicians, Roles and Responsibilities in Aeromedical Evacuation*

AFJH 41-307, *Aeromedical Evacuation Nursing Considerations and Standards*

AFJI 41-301, *Worldwide Aeromedical Evacuation*

AFJMAN 41-313, *Aeromedical Evacuation Documentation*

AFMAN 23-110 , *USAF Supply Manual* (formerly AFM 67-1, Volume. V, *Air Force Medical Management System--General*

AFM 171-190, *Air Force Operations Resource Management System (AFORMS)*

DPSC Handbook 4140.1, *Consolidated Defective Medical Material List*

TA 887, *Strategic and Tactical Aeromedical Evacuation (AE) In--Flight Kits (WRM)*

TA 903, *Aeromedical Staging Flight (WRM)*

Abbreviations and Acronyms

ACC—Air Combat Command

ADVON—Advanced Echelon

AE—Aeromedical Evacuation

AECC—Aeromedical Evacuation Control Center

AECM—Aeromedical Evacuation Crew Member

AECOT—Aeromedical Evacuation Contingency Operations Training

AELT—Aeromedical Evacuation Liaison Team

AEOO—Aeromedical Evacuation Operations Officer

AEOT—Aeromedical Evacuation Operations Team

AERC—Aeromedical Evacuation Readiness Committee

AES—Aeromedical Evacuation Squadron

AET—Aeromedical Evacuation Technician

AFCC—Air Force Component Commander

AFH—Air Force Handbook

AFI—Air Force Instruction

AFJH—Air Force Joint Handbook

AFJI—Air Force Joint Instruction

AFJMAN—Air Force Joint Manual

AFM—Air Force Manual

AFORMS—Air Force Operations Resource Management System

AFOSH—Air Force Occupational Safety and Health

AFPD—Air Force Policy Directive

AFR—Air Force Regulation

AFRES—Air Force Reserve

AFSC—Air Force Specialty Code

AFTO—Air Force Technical Order

AMC—Air Mobility Command

AMCR—Air Mobility Command Regulation

ANG—Air National Guard

AOC—Air Operations Center

ARC—Air Reserve Components

ARM—Aeromedical Readiness Mission

ASF—Aeromedical Staging Facility

ASMRO—Armed Services Medical Regulating Office

COMAMC—Commander Air Mobility Command

CONUS—Continental United States

CRAF—Civil Reserve Air Fleet

DEPMEDS—Deployable Medical Systems

DIRAEFOR—Director of Aeromedical Evacuation Forces

DOC—Designed Operational Capability

DoD—Department of Defense

DPSC—Defense Personnel Support Center

FE—Flight Examiner

FI—Flight Instructor

FN—Flight Nurse

GPMRC—Global Patient Movement Requirements Center

HQ ACC/SG—Headquarters Air Combat Command/Office of the Surgeon General

HQ AMC/SG—Headquarters Air Mobility Command/Office of the Surgeon General

IFN—Instructor Flight Nurse

IMP—Invited Medical Personnel

IMT—Instructor Medical Technician

JCAHO—Joint Commission on Accreditation of Healthcare Organizations

JMRO—Joint Medical Regulating Office

MACR—Military Airlift Command Regulation

MAJCOM—Major Command

MASF—Mobile Aeromedical Staging Facility

MCD—Medical Crew Director

MCR—Multi-Command Regulation

MERC—Medical Equipment Repair Center

MTF—Medical Treatment Facility

M&E—Monitoring and Evaluation

NCO—Noncommissioned Officer

NOS—Not Otherwise Specific

OPR—Office of Primary responsibility

OSHA—Occupational Safety and Health Agency

PACAF—Pacific Air Force

POA—Power of Attorney

QI/RM—Quality Improvement/Risk Management

SOC—Standards of Care

SORTS—Status of Resources and Training System

TA—Table of Allowances

TACC—Tanker Airlift Control Center

TO—Technical Order

TPMRC—Theater Patient Movement Requirements Center

USAF—US Air Force

USAFE—United States Air Forces in Europe

UTC—Unit Type Code

USTRANSCOM—United States Transportation Command

WARMED PS—Wartime Medical Planning System

Terms

Aeromedical Evacuation—The movement of patients under medical supervision to and between medical treatment facilities by air transportation (Joint Pub 1-02).

Aeromedical Evacuation Control Center—The control facility established by the commander of an air transport division, air force, or air command. It operates in conjunction with the command movement control center and coordinates overall medical requirements with airlift capability. It also assigns medical missions to the appropriate AE element in the system and monitors patient movements.

Aeromedical Evacuation Crew Member—Qualified flight nurses, AE technicians, unqualified student

trainees performing AE duties under the direct supervision of a qualified instructor or flight nurse, and flight surgeon crew augmentees added to increase crew capability.

Aeromedical Evacuation Flight Surgeon—Qualified flight surgeon augmenting the aeromedical evacuation crew in order to increase crew capabilities.

Aeromedical Evacuation Liaison Team—An AELT consists of two Medical Service Corps officers, three radio operators, and a flight nurse that is deployed to provide a direct communications link between the user service requesting AE and the AECC.

Aeromedical Evacuation Operations Officer—A Medical Service Corps officer, medical administration specialist, or technician (AFSC 4A0XX) who is assigned to the AE system to perform duties outlined in this instruction.

Aeromedical Evacuation Operations Team—This element of the AE system works with the regional AECC to oversee all strategic AE activities and personnel within its area of responsibility. At senior lodger stations within CONUS, the AEOT coordinates:

- AECM shelter and transportation.
- Security of equipment and medications.
- Return of personnel and equipment to the theater of operations.

Aeromedical Evacuation Technician—A medical service apprentice, craftsman, or superintendent (AFSC X4N0XX) who is qualified as outlined in MCR 51-1, Vol. 2, *Aircrew Training,* to perform AECM duties.

Aeromedical Staging Facility—A medical facility (normally 50 to 250 beds) located on or near an air base or airstrip to receive, administratively support, process, transport (on the ground), feed, and provide limited health care for patients entering, in the midst of, or leaving an aeromedical evacuation system.

Aeromedical Readiness Missions—Training missions using simulated patients to prepare AECMs for moving patients during wartime.

Aircraft Commander—A qualified pilot who commands and controls an aircraft during an AE mission. In matters of flight safety, crew duty waivers, use of non-certified medical equipment, or operational considerations, the AC's decisions are final. The AC commands all persons aboard the aircraft according to **Chapter 2**chapter 2 of each MCR 55-series.

Air Force Component Commander—In a unified, sub-unified, or joint task force command, the Air Force commander who oversees all air operations.

Air Force Operations Resource Management System—This automated system provides air crew managers at base level with a single source of information on the readiness and experience level of the air crew force.

Air Reserve Components—All units, organizations, and members of the Air National Guard (ANG) and Air Force Reserve (AFRES).

Armed Services Medical Regulating Office—A joint activity reporting directly to the Commander in Chief, US Transportation Command; the Department of Defense single manager for the regulation of movement of Uniformed Services patients. The Armed Services Medical Regulating Office authorizes transfers to medical treatment facilities of the Military Departments or the Department of Veterans Affairs and coordinates intertheater and CONUS patient movement requirements with the appropriate

transportation component commands of US Transportation Command.

Augmented Crew—A medical crew that adds additional Flight Nurses (FNs) and Aeromedical Evacuation Technicians (AETs) in order to extend crew duty time, and Flight Surgeons and Respiratory Technicians to increase crew clinical capabilities.

Civil Reserve Air Fleet Stage III—This stage involves DoD use of civil air resources owned by a US entity or citizen that the air carriers will furnish to the DoD in a time of declared national defense-oriented emergency or war, or when otherwise necessary for the national defense. The aircraft in this stage are allocated by the Secretary of Transportation to the Secretary of Defense. The Secretary of Defense may authorize activation of this stage, permitting the Commander, Air Mobility Command, to assume mission control of those airlift assets committed to CRAF Stage III (Joint Pub 1-02).

Combat Area—A restricted area (air, land, or sea) which is established to prevent or minimize mutual interference between friendly forces engaged in combat operations (Joint Pub 1-02).

Combat Zone—

1. That area required by combat forces for the conduct of operations.
2. The territory forward of the Army rear area boundary (Joint Pub 1-02).

Communications Zone—Rear part of the theater of operations (behind but contiguous with the combat zone) which contains the lines of communications, establishments for supply and evacuation, and other agencies required for the immediate support and maintenance of the field forces (Joint Pub 1-02).

Continental United States (CONUS)—United States territory, including the adjacent territorial waters, located within North America between Canada and Mexico (Joint Pub 1-02).

Crew Duty Time—See applicable MCR 55 series.

Director Mobility Forces—The DIRMOBFOR is responsible to the theater Air Force Component Commander (AFCC) for directing the operation of theater-assigned or attached airlift missions, and to the Commander Air Mobility Command for monitoring and coordinating USTRANSCOM-assigned airlift missions. The theater AFCC exercises operational control of applicable theater assigned/attached airlift forces through the DIRMOBFOR. The theater AFCC may appoint a DIRMOBFOR from theater staff, or, when requested, COMAMC will nominate a DIRMOBFOR for USCINCTRANS approval and theater Commander in Charge concurrence. The DIRMOBFOR will task intratheater-validated missions through the Air Operations Center. The DIRMOBFOR provides Air Mobility Command Tanker Airlift Control Center the status of strategic air mobility operations supporting the theater and is the strategic air mobility liaison to the AFCC.

Flight Examiner—A qualified crew member who may give flight evaluations in accordance with AFI 11-406.

Flight Nurse—A Nurse Corps officer who:

- Has completed a recognized course of study in aerospace nursing.
- Appears on aeronautical orders as a flight nurse.

Global Patient Movement Requirements Center—Is responsible for coordinating all patient movement once the mission arrives at the CONUS reception aerial port, ensuring the patients are continued to final destinations as appropriate, and notifying receiving MTFs of aircraft arrival time as well as types and numbers of patients to be off loaded. The GPMRC will be the control point for all

CONUS AE aircraft and crews.

Hazardous Cargo—Hazardous materials in quantities which require their identification on flight plans and messages and as part of arrival/departure notifications.

Instructor Medical Technician or Instructor Flight Nurse—A qualified AECM who may instruct an unqualified medical crew member per AFI 11-406 and MCR 51-164, Vol. 2, *Aeromedical Evacuation Crewmember Briefings and Publication*.

Invited Medical Personnel—US Armed Forces medical personnel traveling in a duty status with official TDY or TAD orders who may accompany aeromedical evacuation missions.

Joint Medical Regulating Office—The office that regulates patients within a geographical area by:

- Assigning specific patients or groups of patients to specific hospitals or specialty treatment centers.
- Advising AECCs and ASFs, along with hospitals and other agencies concerned, on patient destination by name, group, diagnosis, or other designated identification.

Medical Crew Director—A qualified flight nurse who supervises patient care and manages AECMs in aeromedical evacuation missions. In matters of in-flight patient care, the physician (if assigned) has final authority over patient care. In the absence of a physician, the MCD is the final authority in in-flight patient care.

Mobile Aeromedical Staging Facility—This facility is an air and ground, mobile, tented unit for temporary casualty staging. Each unit can process up to 200 patients each day, with an emergency surge capability of up to 300 patients each day for a limited duration. The MASF operates next to the taxiways of a Forward Operating Base that tactical airlift aircraft use to supply combat ground forces.

Senior Lodger—A CRAF carrier that has contractually committed itself to support civil aircraft and crews for the AMC as they transit between theaters after the Secretary of Defense has activated Stage III of the CRAF.

Strategic Aeromedical Evacuation—The phase of evacuation of patients out of the theater of operations to a main support area (AFM 11-1).

Strategic Airlift—The continuous or sustained movement of units, personnel, and materiel in support of all DoD agencies between area commands, between the continental United States (CONUS) and overseas areas, and within an area of command when directed. Strategic airlift resources possess a capability to airland or airdrop troops, supplies, and equipment for augmentation of tactical forces when required (AFM 11-1).

Tanker Airlift Control Center—The Air Mobility Command direct reporting unit responsible for tracking and controlling operational missions for all activities involving forces supporting USTRANSCOM's global air mobility mission. The TACC is comprised of the following functions: current operations, command and control, logistics operations, aerial port operations, aeromedical evacuation, flight planning, diplomatic clearances, weather, and intelligence (Joint Pub 3-17).

Tactical Aeromedical Evacuation—That phase of evacuation which provides airlift for patients from the combat zone to points outside the combat zone and between points within the communications zone (Joint Pub 1-02).

Theater Aeromedical Evacuation System—The deployed elements of tactical aeromedical evacuation

units that provide theater aeromedical evacuation during an exercise or contingency operation. A TAES includes:

- At least one AE command and control element.
- An aeromedical evacuation coordination center.
- One mobile aeromedical staging facility.
- One liaison team.
- The required number of aeromedical evacuation crews.

Theater Patient Movement Requirements Center—The TPMRC is a unified theater office designated to regulate patients within the theater assigned by monitoring theater casualty reception hospital bed availability and assigning specific patients or groups of patients to specific MTFs. The TPMRC normally interfaces with and controls the regulation of patients from 3E to 4E medical facilities and coordinates regulation of patients to CONUS from 4E medical facilities. Subject to specific theater concept of operations, the TPMRC does not normally regulate patients between other echelons; this regulation is routinely a Component Service responsibility.

Attachment 2

RCS: HAF-SG(D)9455, DAILY AE MISSION ACTIVITY REPORT

A2.1. This report covers all AE mission activity for the previous 24 hour period (0001-2359 hrs, local, for each reporting AECC) and contains as a minimum:

- The number of AE missions (scheduled and unscheduled) within each theater of operation (CONUS, European Command, Pacific Command, Southern Command, Central Command). ***Note: Information will be grouped by type of aircraft.***
- The number of sorties, litter patients, ambulatory patients, and attendants for each mission or group of missions.
- Unscheduled mission information will include mission number, an abbreviated itinerary, and patient data (precedence, age, sex, status, diagnosis, and patient category to reflect revenue reimbursable categories), and any pertinent mission information.
- One copy of AF Form 3836 and AF Form 3835 for any scheduled or unscheduled mission which has been approved for AE use.
- One copy of AF Form 3839, **Patient Regulating Data Collection Sheet,** for any urgent or priority patient moved via any unscheduled or "opportune" mission.

A2.2. This report is designated emergency status code C-2. Continue reporting during emergency conditions, normal precedence. Submit data requirements in this category as prescribed or as soon as possible after submission of priority reports. Continue reporting during MINIMIZE.